PHYSICIAN CLEARANCE FOR PARTICIPATION IN THE NASA EXCHANGE PHYSICAL EXERCISE PROGRAM

Participant's Name:	Phone:

NOTE TO PHYSICIAN: Any special medical precautions are the responsibility of the exerciser and his/her physician. If an exercise prescription is written by a participant's physician, the exercise facility personnel will help train the individual in the use of the appropriate equipment, if available. The NASA Exchange exercise staff is trained in the use of the facility's equipment which is similar to that found in commercial health and fitness clubs. They instruct participant's in the proper use of the equipment. Exercisers are taught to monitor their pulse rate, to exercise within an age-specified training heart rate zone, and to note their subjective feelings upon exertion.
Call 544-0252 or 544-7564 if you have questions.

The evaluating physician shall, as a minimum, determine the participant's current health status in the areas of:
(Physician should checkmark or otherwise annotate a response for each category)

	NO PROBLEM	A PROBLEM/COMMENT
Blood Pressure (high or low)	✔	
Heart (coronaries, valves, rhythm)		
Vascular (DVT, stroke, etc.)		
Respiratory (COPD, asthma, etc.)		
Endocrine (Diabetes, thyroid, etc.)		
Obesity/Eating Disorder		
Epilepsy/Nerve/Psychiatric		
Dizziness/Vertigo/Fall risk		
Back or Neck Surgery/Pain		
Joint Surgery (Affected joints)		
Arthritis (Affected joints)		
Osteoporosis		

Precautions/Limitations/Medications/Other Pertinent Information:

The above named individual is medically cleared to use the MSFC/NASA Exchange exercise facility.

Type or Print Physician's Name: ☐ NASA ☐ Personal	Office Phone #:
Physician's Office Address:	
Physician's Signature:	Date:

NOTE: This clearance is good for three (3) years from the above date. In the interim, if there are any changes in your medical status, the exerciser and his/her physician should advise the exercise facility staff.

This information to be completed by exercise staff at time of initial evaluation:			
Date:	Blood Pressure:	Height:	Weight (LB):

PHYSICAL ACTIVITY READINESS QUESTIONNAIRE

To be completed by participant:

Participant's Name: (Last, First, MI):	Birth Date:
Social Security # (Last 6 digits only):	Mail Code/Organization (if applicable):
Office Phone:	Cell Phone:

E-mail Address:

Are you employed by: ☐ NASA ☐ Contractor ☐ Non-employee

Other Member Status: ☐ Dependent ☐ Retiree

Is this your first time using the exercise facility? ☐ Yes ☐ No

Emergency Contact:	Relation: ☐ Spouse ☐ Child ☐ Parent ☐ Other _____
Phone: _____ Cell Phone: _____	

QUESTION	YES	NO
Has a doctor ever said that you have a heart condition and recommended only medically-supervised activity?		
Do you have chest pain or shortness of breath brought on by physical activity?		
Has a doctor ever recommended medication for your blood pressure, blood sugar, or a heart condition?		
Do you have a history of smoking or asthma?		
Have you on one or more occasions lost consciousness or fallen over as a result of dizziness, vertigo, seizure, or epilepsy?		
Do you have a neck, back, bone or joint problem that could be aggravated by the proposed physical activity?		
Have you been diagnosed with an eating disorder or have had gastric bypass surgery, or any other weight-related problem?		
Are you aware, through your own experience or a doctor's advice, of any other physical reason that would prohibit you from exercising without medical supervision?		

If "Yes" to any of the above questions, please explain:

By my signature below, I acknowledge my responsibility to maintain current medical clearance, to advise the exercise staff of changes in my medical profile, and to abide by all rules and policies in place while using this facility.

Participant's Signature:	Date: